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Inpatient's Perspective on Nursing Care; Affecting Factors

Marjan Laal [a] *

[a] Tehran University of Medical Sciences, Sina Trauma & Surgery Research Center, Sina Hospital, Tehran 11555/3876, Iran

Abstract

A cross- Sectional study conducted to find out patients' perspectives of nursing performance and the factors influencing their satisfaction, on 250 patients hospitalized in 2 hospitals of Sanandaj, Iran in 2006, using Quality from the Patients' Perspective (QPP) questionnaire. Generally, our patients satisfied weakly (48.4%) with nursing care. Inpatient satisfaction showed a significant relation to age (p=0. 000), gender (p=0. 001), level of education (p=0. 001), marital status (0.03), job (p=0. 005), personal recommendation about care (p=0. 000), family members (p=0. 005), place of residing (p=0. 001), previous hospitalization(s) (p=0. 000), shift of nursing (p=0. 000), undergoing surgery (p=0. 000) and the medical center (0.002). No significance was found in relation to duration of hospital stay (p=0. 13).

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Keywords: patient satisfaction, perspective, quality, affecting factors, nursing care;

1. Introduction

There is increasing evidence that more patient-centered processes of care can improve the quality of care (QOC) and health outcomes (Viner, R. M., 2007; Cleary, P. D., 1999; Romana, H. W., 2006), so the use of patient perceptions of care for systems improvement seems to be important (Co, J. P. T., et al., 2003). Patient centeredness has become a desideratum of health care reform (Krumholz, H. M., 2010).

Nurses care for the sick and injured in hospitals, where they work to restore health and alleviate suffering (Starr, P., 1984). Patients' safety is of paramount concern that underlies the nursing care and is a responsibility of for all health care providers (Sonfield, A., 2005; Griffin, T., 2010). During the past century, nurses have risen from a position of subjugation to the second highest concern on the minds of healthcare executives (Clark, P. A., et al., 2007). These concerns are grounded in reality (Wilde, B., et al., 1993).

Nurses have seen their role at the bedside, dealing with the needs of the individual patient, and were unlikely to consider whether their nursing care was delivered in the most effective and efficient way with the maximum utilization of scarce resources. Therefore it is important that nurses understand the importance of one of the underlying concepts of quality care, and that is accountability (Kavari, S. H., 2006; Wensley, M., 1992).

In the current economic climate, health organizations experiencing Budget reductions must be able to measure the effect on the health care consumer whilst doing more with less (Bauman, M. K., 1991)); therefore it seems necessary to ask the patients for their perception of care received.

* Corresponding author: Marjan Laal. Tel.: +98-216-675-7001-3, fax: +98-216-675-7009.
E-mail address: laal.marjan@gmail.com

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2.1. Material and method

A cross-sectional study took place on 250 patients, hospitalized in 2 hospitals (Besat and Tohid) of Sanandaj-Iran. We excluded patients of the pediatric wards. Data was gathered through filling questionnaires by personal interviews. The questionnaires were based on patients' perceptions of the quality of care (QPP) developed by Widle and coworkers (1993, 1994). The QPP is a theoretical model of QOC from a patient perspective which consists of 40 items covering 17 factors. The model stipulates that patients' perceptions of quality of care are formed by their encounters with an existing care structure and by their systems of norms, expectations, and experiences.

There are four dimensions of QOC within this framework: the medical-technical competence of the caregivers, the physical-technical conditions of the care organization, the degree of identity-orientation in the attitude and actions of the caregivers, and the socio-cultural atmosphere of the care organization. We used a 3-point Likert-type response scale for each item, as: 1=not at all, 2=some and 3=highly. Statistical significance was assumed at $p<0.05$.

2.1.1. Results

Two-hundred fifty patients aged 13-72 (mean=43) were included in this study. The hospitalization stay was 4-6 days in 96 (38.2%) patients. Demographic characteristics of the patients are summarized in table 1.

Table1. Demographic characteristics of 250 patients in 2 hospitals

Profile of patients	Number	Percent (%)	Profile of patients	Number	Percent (%)
Age range			Job		
20-29y*	42	16.8	Housekeeper	63	35.2
30-39y	58	23.2	Retired	18	7.2
40-49y	81	32.4	Official	44	17.6
50-59y	42	16.8	Self-employed	80	32
>60y	27	10.8	Jobless	45	18
Gender			Residing place		
Female	88	35.2	City	71	28.4
Male	162	64.8	Suburb	66	26.4
Marital status			Village	113	45.2
Single	33	13.2	Hospitalization		
Married	204	81.6	First time	114	45.6
Divorced	7	2.8	Second time	89	35.6
Defunct partners	6	2.4	Several times	47	18.8
Family member			Surgical operation		
1-3	48	19.2	Yes	52	20.8
4-6	113	45.2	No	198	79.2
7-9	89	35.6	Hospital		
Level of education			Besat	120	48
Illiterate	135	54	Tohid	130	52
Primary school	17	6.8	Recommendation		
High school	75	30	about QOC		
University	23	9.2	Yes	52	20.8
			No	198	79.2

*=*year*

In general, QOC in our study was good 48 (19.2%), medium 81 (32.4%) and weak 121 (48.4%), as presented in figure 1. Gender of patients had significant difference (p=0. 001) in relation to QOC. Eighty-eight females perceived QOC as: 40 (45.5%) good, 35 (39.8%) medium and weak 13 (14.8%) and in 162 males: 8 (4.9%), 46 (28.4%) and 108 (66.7%), accordingly. Females were more satisfied with the staff performance.

QOC showed significant difference (p=0. 000) with the age group. Patients with the age range of 30- 39 and ≥50 years rated quality of nursing care high. In relation to marital status, the 4 groups of single, married, divorced and

defunct partner patients had significant (p=0.03) different perceptions of QOC. Single patients rated QOC lower than the other groups.

The 3 groups of family members had significant different perceptions of QOC (p=0.005). In our patients, those with family members of 4-6, perceived more satisfied. Level of education of participants had significant different points of view on QOC (p=0. 001). As the level of education upgraded, QOC scored lower. Our patients had different jobs including: housekeeper, retired, official, self-employed and those with no job. Job showed significant difference (p=0. 005) with QOC patients experienced. Perceived QOC was higher and rated more favorable in patients that were self-employed or retired more agreeable than the other participants, as displayed in figure 2.

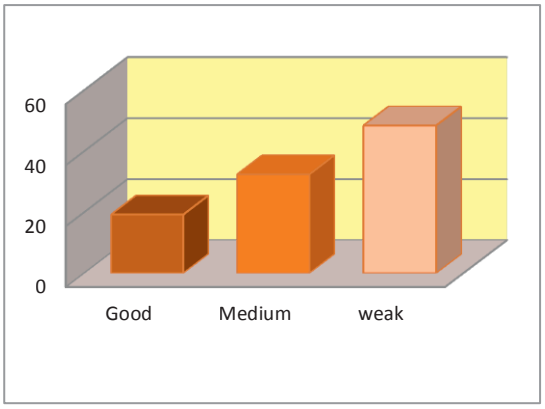

Fig.1. QOC in 250 patients in 2 hospitals of Sanandaj-Iran

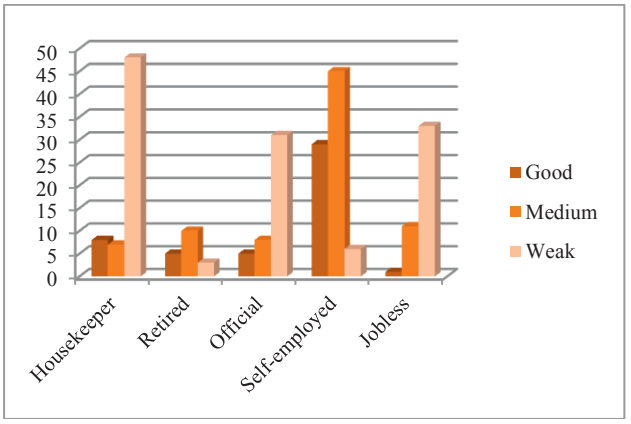

Fig.2. QOC and Job in 250 patients in 2 hospitals of Sanandaj-Iran

Patients residing in 3 places had significant different perceptions of QOC (P=0. 001). Patients residing in villages scored higher rates of QOC than those residing in a city or suburb. We also found a significant relationship between hospitalization times and the QOC that patients perceived (P=0. 000), those with more hospitalizations rated QOC higher. Patients perceived QOC in different shifts of nursing work, not the same. They perceived QOC higher in the morning shift of nursing work (p=0. 000). We also found significant differences (P=0. 000) between patients underwent surgery with the other patients. There was a significant relationship between perceived QOC in those had recommendation about the care (p=0. 000), with those didn't have. Patients in Tohid center more satisfied with QOC and significantly different (p=0.002) from those hospitalized in Besat center. In this study no significant relationship was found between the duration of hospital stay and the perceived QOC (p=0. 13).

2.1.1.1. Discussion

Quality is an illusive concept with different meanings to different people. Providers often define quality in terms of patient outcomes, professional standards of practice, predetermined criteria used to measure quality, and even subjective opinion. Patients describe quality in terms of the interpersonal aspects of care, how well they were treated, and the responsiveness of the provider to their needs (Stichler, J. F. & Weiss, M. E., 2000).

Patients usually cannot assess the technical quality of their care; however, examining a hospitalization through the patients' eyes can reveal important information about the QOC. Unfortunately, poorly coordinated hospital care is not unusual (Krumholz, H. M., 2010). Patients are the only source of information about whether they are treated with dignity and respect or not, and are the best source of information about a hospital system's function. Their experiences often reveal how well a hospital system is operating and can stimulate important insights into the kinds

of changes that are needed to close the chasm between the care provided and the care that should be provided (WHO, 1998).

In this study, patients satisfied with QOC in 51.6% (good and moderate) and 48.4% were not agreeable with it. Grøndahl et al. reported high QOC rating in their study (Grøndahl, V.A., et al., 2011). They noted that age, sex and self-reported psychological well-being are three person-related conditions predict patients' perception of QOC.

Widle, B., et al. (1999) reported the lowest satisfaction in younger and well-educated patients who stayed for a short period of time in hospital. Patients' perceptions of the care they actually received indicated increasingly more positive evaluations with increasing age, as this study documented. In our study, female rated QOC higher than the male patients, as the study of Blomberg et al showed (Blomberg, F., et al., 2010).

In this study, significance was found in relation to the level of education. Well-educated patients were less satisfied with QOC. Duration of hospital stay had no significant relation to the perception of QOC, this study showed. One of the significant trends in the development of modern health care is the involvement of patient / clients in the management of their care and treatment. To support this development it is important to acknowledge that the experiences of patients/clients of health care vary considerably. Some may have an occasional intervention while others have a more permanent and long-term relationship with a service provider depending on the nature and extent of their need. Person-centered health care respects the dignity and value of each person. It is entirely desirable and proper that the views of patient/clients should be sought on their experiences and expectations of health care (HBE, 2003).

Patients' perspectives on QOC showed a significant relation to marital status. Also, it showed significance in relation to offering any recommendation about QOC. Kols and Sherman (1998) stated that clients may also say they are satisfied with care because they want to please the interviewer, worry that care may be withheld in the future, or have some cultural or other reason to fear complaining.

Previously the health care industry was considered above being questioned about the QOC, but nowadays, health care is a major industry and each hospital is accountable to its consumers. The availability and quality of health care are determined by the values and expectations of the consumers (Kavari, S. H., 2006). Bauman (1991) stresses that in the past, health organizations have concentrated on establishing Quality Assurance programs according to the structural standards of the particular institution. Gradually, there has been a shift to greater emphasis on the process of patient care in the areas of patient assessment, teaching and discharge planning.

Patients need to be treated with dignity and respect and feel confident that the procedures are designed to optimize safety and outcomes. Patients have an important and unique perspective on how well hospitals are run (Clearly, P. D., 2003). As techniques to measure the quality of health care proliferate and improve, health professionals are beginning to accept that patient/clients and their families hold unique vantage points as expert witnesses of care and that they should plan their services to reflect the needs of patient/clients (Delbanco, T. L., 1996).

In the past decade, quality issues in health care have gained increasing interest. Several tools have emerged to continuously monitor hospital care processes and to improve and control different areas of care. To date, most studies have focused on medical and economic criteria, but attempts have also been made to include the customer's or patient's judgment about the care that health services supply. Besides democratic and ethical reasons for assessing patient's views on health care, the findings from such studies can lead to better use of allocated resources. Continuous measurement of our client's opinions about products and services given by the medical community also provides a basis for quality assurance and different forms of benchmarking (Nathorst-Böös, J., et al., 2001).

2.1.1.1.1. Conclusion

Nursing staff need to understand that inefficiency, inconveniences, and breakdowns in processes of care are not inevitable but rather are consequences of the way the hospital is organized and run. It is necessary to convey to everyone in a hospital that it is a priority to redesign care system how to meet patient needs, including the provision of safe and effective care. The results of this study demonstrate that several factors play a role in a patient's perception of QOC. In this study, age, gender, marital status, number of family members, level of education, job of

patients, place of residing, previous hospitalization(s), shift of nursing, having surgical operation or recommendation about QOC and the center delivering care, were conditions significantly influenced QOC perception. One relatively easy and inexpensive way to improve QOC is routine queries of patients about their care experiences and suggestions for improvement. By relying on the insights of patients, the staff will be able to close the gap between patients' experiences and what they perform.

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